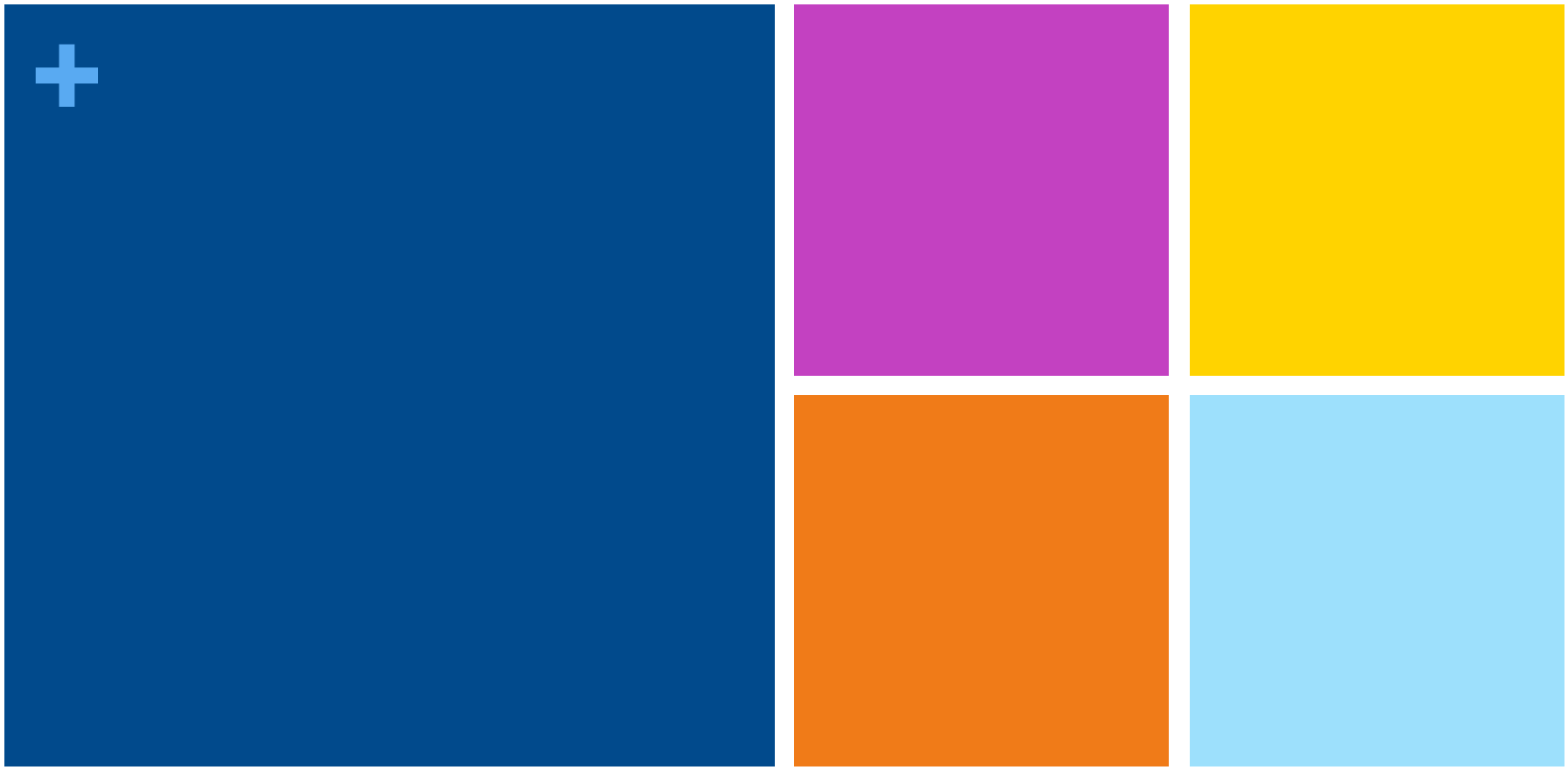


Understanding Medicare

What is Medicare?

- Health insurance for people
  - Age 65 and older
  - Under age 65 with certain disabilities
  - Any age with End-Stage Renal Disease (ESRD)
- Administered by
  - Centers for Medicare & Medicaid Services (CMS)
- Enroll through
  - Social Security
  - Railroad Retirement Board (RRB)

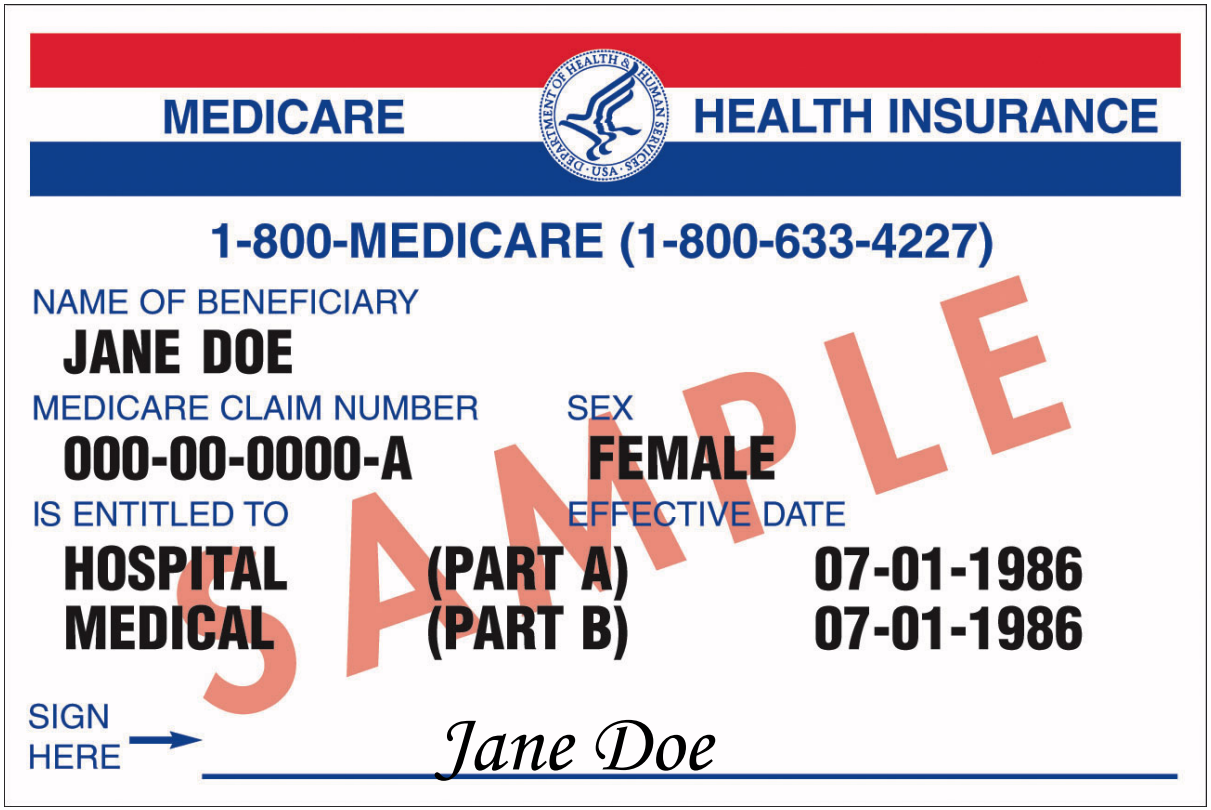
At A Glance

- Medicare has four parts
  - Part A – Hospital Insurance
  - Part B – Medical Insurance
  - Part C – Medicare Advantage Plans
  - Part D – Prescription Drug Coverage

Original Medicare

- Red, white, and blue Medicare card
- Part A and/or Part B
- Go to any provider that accepts Medicare
- You pay
  - Part B premium
    - Part A free for most people
  - Deductibles
  - Coinsurance or copayments

Medicare Card (front)



Enrollment in Medicare

- Apply 3 months before age 65
  - Social Security Association (SSA) will enroll you in Medicare starting the first day of the month (upon meeting requirements)
  - Do not need to be retired
- Auto Enrollment
  - If you are already receiving Social Security benefits
  - If receiving Railroad Retirement benefits

Medicare Part A (Hospital Coverage)

- Part A premium is free for most people*
  - *People with less than 10 years of Medicare-covered employment can pay a premium to buy in to Part A
- What's Covered:
  - Hospital inpatient care, skilled nursing facility (SNF) care, home health care, hospice care, and blood work.
- Charges based on "benefit period"
  - Inpatient hospital care and SNF services
  - Begins day admitted to hospital and ends when no care received in a hospital or SNF for 60 days in a row.
  - You pay deductible for each benefit period, but there is no limit to number of benefit periods

Inpatient Hospital Stays

- Covered services:
  - Semi-private room
  - Meals
  - General nursing
  - Other hospital services and supplies
- Includes:
  - Inpatient care in Acute Care Hospitals
  - Critical Access Hospitals
  - Inpatient Rehabilitation Facilities
  - Long Term Care Hospitals
- 190-day limit for inpatient mental health care in a lifetime

Paying for Hospital Stays

- For inpatient Hospital stays in 2013 you pay
  - $1,184 total deductible for days 1 – 60
  - $296 co-payment per day for days 61 – 90
  - $592 co-payment per day for days 91 – 150 (60 lifetime reserve days)
  - All costs for each day beyond 150 days

Skilled Nursing Facility (SNF) Care

- Conditions of coverage (must meet ALL):
  - Require daily skilled services
    - Not long-term or custodial care
  - At least 3 consecutive days of inpatient hospital care for a related illness or injury
  - Admitted to SNF within 30 days of hospital discharge
  - MUST be a Medicare participating SNF
- What's covered:
  - Semi-private room, meals, skilled nursing care, physical, occupational, speech-language therapy, medical social services, medications, medical supplies/equipment, ambulance transportation, and dietary counseling

Paying for SNF Care

- For each benefit period in 2013 you pay:
  - $0 for day(s) 1–20:
  - $148 per day for days 21–100
  - All costs after 100 days
- Must meet requirements for Medicare-covered stay
  - Does NOT include custodial care (if it is the only care you need)
  - Generally, skilled care is available only for a short time after a hospitalization whereas custodial care may be needed for a much longer period of time.

Home Health Care

- For as long as you are eligible*
  - *Limited hours and days per week
- Conditions:
  - Doctor must make a plan for your care at home
  - Must need specific skilled services
  - Must be homebound
  - Home health agency must be Medicare-approved
- Payment
  - With Original Medicare you pay:
    - Nothing for covered home health care services
    - 20% of the Medicare-approved amount for covered durable medical equipment

Home Health Care Coverage

- Covered services
  - Part-time/intermittent skilled nursing care
  - Therapy
    - Physical
    - Occupational
    - Speech/language
- May also include
  - Medical social services
  - Some home health aide services
  - Durable medical equipment/supplies

Hospice

- Special care for terminally ill and family
  - Expected to live 6 months or less
  - Focuses on patient comfort, **not on curing the illness**
- Doctor must certify for each "period of care"
  - Two 90-day periods
  - Unlimited 60-day periods
- Hospice provider must be Medicare-approved
- Coverage:
  - Medical equipment and supplies, drugs for symptom control and pain relief, short-term hospital inpatient care, respite care in a Medicare-certified facility, home health aide and homemaker services, social work services, dietary counseling, and grief counseling

Hospice Payment

- Payment by Original Medicare
  - You pay up to $5 for prescription drugs
  - You pay 5% for inpatient respite care
    - Amount can change each year
- Room and board generally not payable

Medicare Part B (Medical Coverage)

- Part B helps cover medically-necessary services:
  - Doctors' services, outpatient care, screenings, etc.
- Enrollment in Part B is an optional coverage
- Enrolled automatically if receiving Social Security
  - To keep Part B, keep the card
  - If you don't want Part B, follow instructions with card

Enrollment in Medicare Part B

- Initial Enrollment Period (IEP)
  - Three months before birthday month, during birthday month, and three months after
- General Enrollment Period (GEP)
  - January 1 through March 31 each year
  - Coverage effective July 1
  - Premium increases 10% for each 12-month period you were eligible but did not enroll
- Special Enrollment Period
  - Sign up within 8 months of the end of employer or union health plan coverage

Paying For Medicare Part B

- Taken out of your monthly payment
  - Social Security
  - Railroad Retirement
  - Federal Government retirement
- For information about premiums
  - Call SSA or RRB
  - OPM if a retired Federal employee
- May be billed every 3 months
- Medicare Easy Pay
- Programs available to help

Medicare Part B Premiums

Yearly Income Filed Individual Tax Return	File Joint Tax Return	Premium
$85,000 or less	$170,000 or less	$104.90
$85,001-$107,000	$170,001-$214,000	$146.90
$107,001-$160,000	$214,001-$320,000	$209.80
$160,001-$214,000	$320,001-$428,000	$272.70
$214,001 or more	$428,001 or more	$335.70

What's Covered Under Part B?

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic tests
- Outpatient therapy
- Outpatient mental health services
- Some preventive health care services
- Other medical services
- Clinical laboratory tests
- Home health services (not covered under Part A)
- Durable medical equipment
- Outpatient hospital services
- Blood Work
- Ambulance service, if other transportation would endanger your health

Part B Preventive Services

- "Welcome to Medicare" Preventative Visit and a yearly "Wellness Visits" thereafter
- Abdominal aortic aneurysm screening
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- Glaucoma tests
- Mammograms (screening)
- Pap test/pelvic exam/ clinical breast exam
- Prostate cancer screening
- Flu shots
- Pneumococcal shots
- Hepatitis B shots
- Smoking cessation
- HIV screenings

Part B Cost of Services

- In Original Medicare you pay
  - Yearly deductible
    - $147 in 2013
  - In most cases, 80% covered by Medicare with a 20% co-pays for services
- Multiple programs available to help pay Part B costs

Original Medicare Assignment

- Only Applies to Original Medicare Part B Claims
- Agreement between
  - People with Medicare, Doctors, and other health care suppliers and Medicare
- Providers agree to
  - Be paid by Medicare
  - Get only the amount Medicare approves for their services
  - Only charge the Medicare deductible and/or coinsurance amount
- Providers who do NOT agree
  - May charge more than Medicare-approved amount
    - Limit of 15% more for most services
  - May ask you to pay entire charge at time of service

Medigap

- Health insurance policies
  - Sold by private insurance companies, plans are A through N
  - Follow Federal and state laws that protect you in every state
  - Must say "Medicare Supplement Insurance"
  - Cover "gaps" in Original Medicare
  - Costs may vary by state, you must purchase a plan where you live
- Same Plan, Different Names
  - Plans issued prior to 1991 are termed "Pre-Standardization plans" (excluding MA, MN, and WI)
  - Plans issued from 1991 – June 2010 are called, "1990 Pans" formerlly known as "Standardized Plans"
  - The NAIC's new term for plans issued beginning June 1, 2010 is "2010 Plans"

How Medigap Policies Work

- Only works with Original Medicare
  - Don't need Medigap if in MA Plan or other Medicare plans
- Can go to any doctor, hospital, or provider that accepts Medicare
  - Except with a Medicare SELECT policy
- You pay a monthly premium
- All Medigap plans must be approved by the IDOI
- A list of all Medigap plans is located on the SHIP website (or via packet in the mail)

Medicare Advantage Plans

- Health plan options approved by Medicare
  - A way to get your Medicare benefits delivered through private companies approved by Medicare
  - Still in Medicare program
  - Still have Medicare rights and protections
  - Still get regular Medicare-covered services
  - May get extra benefits
    - Such as vision, hearing, or dental care
  - May be able to get prescription drug coverage (Part D)

- Different Advantage Plans
  - Health Maintenance Organization (HMO)
  - Preferred Provider Organization (PPO)
  - Private Fee-for-Service (PFFS)
  - Special Needs Plan (SNP)

How Advantage Plans Work

- Get Medicare-covered services through the plan, all of Part A and Part B covered services
- Some Plans may provide additional benefits
- Can include a prescription drug coverage
- You have to stay in a certain network of hospitals and providers
- Co-pays and deductible are different than Original Medicare

Advantage Plan Enrollment

- Initial Coverage Election Period
  - Seven month period begins three months before you turn 65
  - Includes the month you turn 65
  - Ends 3 months after you turn 65
- Annual Election Period
  - October 15th – December 7th each year
  - Coverage starts January first of next year
- Annual Disenrollment Period
  - January 1st – February 14th every year (coverage begins the first of the month after you switch)
  - May also join a Medicare Part D plan during change

Part D (Prescription Coverage)

- Available for all people with Medicare
- Provided through
  - Medicare Prescription Drug Plans
  - Medicare Advantage Plans
  - Other Medicare plans
- Who Can Join
  - Requirements:
    - Have Medicare Part A, Part B, or both
    - Live in plan service area
    - Enroll in a Medicare prescription drug plan

Enrollment in a Part D Plan

- When first eligible for Medicare
  - Beginning 3 months before first month of Medicare eligibility, month during, and three months after (7 months total)
- During specific enrollment periods
  - Annual Coordinated Election Period
  - October 15th – December 7th each year
  - Special Enrollment Periods
- Some people are enrolled automatically

Switching Your Part D Plan

- Annual Election Period
  - October 15th through December 7th, 2013
- Special Enrollment Periods
  - Permanently move out of plan service area
  - Lose creditable prescription drug coverage
  - Enter, reside in, or leave a long-term care facility
    - Like a nursing home
  - Qualify for Extra Help
  - Have other exceptional circumstances

Late Enrollment Penalties

- The late enrollment penalty is calculated by multiplying 1% of the national base beneficiary premium ($31.17 in 2013) times the number of full, uncovered months that you were eligible but didn't join a Medicare Part D plan and went without other creditable prescription drug coverage.
- This amount is rounded to the nearest $.10 and added to your monthly premium. You may have to pay this penalty for as long as you have a Medicare drug plan.

Part D Costs

- Costs vary by plan, most people will pay:
  - Monthly premium
  - Annual Deductible, $325 in 2013
  - After the deductible for the next $2,970, you will pay 25% and the plan will cover 75% of your drug costs.
  - When your total drug costs reach $2,970, your initial drug plan coverage will end.
  - Part D enrollees will receive a 52.5% discount on the total cost of their brand-name drugs and pay a maximum of 79% co-pay on generic drugs while in the coverage gap. The full retail cost of the drugs will still apply to getting out of the coverage gap.
  - Once your total out of pocket drug costs (not including the monthly premiums) reach $4,750 your catastrophic coverage will begin.
    - Your plan will then cover up to 95% of your drug costs. You will pay either $2.65 for generic or $6.60 for brand name drugs or 5% of the cost which ever is greater.

Getting "Extra Help" with Part D

- What is Extra help?
  - Full or partial help with drug plan costs for people with limited income and resources
  - Social Security or State makes determination
  - Both income and resources are counted
  - Some groups are automatically eligible
    - People with Medicare and Medicaid
      - Supplemental Security Income (SSI) only
      - Medicare Savings Programs
- How to apply for Extra Help
  - Paper application (from Social Security Office)
  - Applying with Social Security at www.socialsecurity.gov on the web
  - Applying through your local Medicaid office
  - LIS/MSP Enrollment Centers, your Local Area on Aging

Extra Help Income/ Assets Limits

- Monthly Income
  - Below 150% of Federal Income Level
    - $1,293 (full) or $1,436 (partial) for an individual
    - $1,745 (full) or $1,939 (partial) for a married couple
    - Even if income is higher, may still be eligible for help
- Asset Limits
  - Up to $8,580 (full) or $13,300 (partial) for an individual
  - Up to $13,620 (full) or $26,580 (partial) for a married couple
    - Includes $1,500/person funeral or burial expenses
    - Counts savings and stocks
    - Does not count the home you currently live in

Hoosier Rx

- Hoosier Rx is Indiana's prescription drug plan for low-income seniors. Hoosier Rx does not consider your assets, it only considers your income.
- To qualify:
  - Indiana resident
  - Age 65 or over
  - Receive a low monthly income
  - Are without insurance that has a prescription drug benefit, you may qualify.
  - Net income in 2013 is:
    - $16,995 or less for an individual
    - $22,935 or less for a married couple
- To apply, call free of charge 1-866-267-4679.

Medicaid

- Medicaid is a Federal-state program that provides health coverage for lower-income people, families and children, the elderly, and people with disabilities.
- If eligible, most health care costs covered
- Income and Assets limits:
  - Individual: $710 in income , $1,500 in assets
  - Married couple: $1,066 in income, $2,250 in assets
- Eligibility for program is determined by State
- Application processes and benefits vary

Medicare Savings Programs

- Programs for people with limited income and resources that help pay some or all of Medicare's premiums.
  - For people with limited income and resources
  - May also pay Medicare deductibles and coinsurance
- Programs include
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-income Medicare Beneficiary (SLMB)
  - Qualifying Individual (QI)

Medicare Savings Program

	Income	Assets
Qualified Medicare Beneficiary	$978 (single)	$7,080 (single)
	$1,313 (couples)	$10,620 (couples)
Specified Low Income Beneficiary	$1,169 (single)	$7,080 (single)
	$1,571 (couples)	$10,620 (couples)
Qualified Individual	$1,313 (single)	$7,080 (single)
	$1,765 (couples)	$10,620 (couples)

For More Information

- 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048
- *Medicare & You 2013* handbook
- Other Medicare publications
- www.medicare.gov
- www.cms.hhs.gov
- SHIP telephone: 1-800-452-4800
  - TTY users should call 1-800-846-0139
- SHIP website: www.medicare.in.gov